KDADS STANDARD POLICY

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Purpose

The purpose of this policy is to explain the Person-Centered Service Plan (PCSP) requirements found in 42 CFR § 441.301, K.A.R. 30-63-1 through 32, and the 1915 (c) HCBS waivers and detail the process for creation of the Person-Centered Service Plan.

Summary

This policy provides requirements for the implementation of a person-centered planning process, and aims to describe for 1915 (c) waiver participants, what to expect though the development and implementation of a person-centered plan. This policy also provides information regarding applicable Person-Centered Service Plan forms and documents, elements for the 1915(c) HCBS waiver's plan of care quality assurance compliance, and the procedures, timelines and responsible parties governing the Person-Centered Service Plan and implementation activities.

Entities/Individuals Impacted

- HCBS 1915 (c) waiver participants and participant designated legal representatives
- HCBS 1915 (c) waiver service providers
- Managed Care Organizations (MCOs)
- KanCare contracted Targeted Case Managers (TCMs)
- Kansas Community Developmental Disability Organizations (CDDOs)
- Kansas Department of Aging and Disability Services (KDADS)
- Kansas Department of Health and Environment (KDHE)

I. General

A. It is <u>not</u> the intent of this policy to combine the Person-Centered Service Plan and Person-Centered Support Plan. The Person-Centered Service Plan represents a broad service plan inclusive of all Medicaid covered services, including healthcare and healthcare services. The Person-Centered Support Plan used in the I/DD Waiver will remain a separate component of the overall Person-

Centered Service Plan, and will be re-titled the Participant Interest Inventory (PII) as explained in Section II. A. c. of this policy. Use of this tool will expand to all HCBS waiver populations, to promote holistic consideration of individual's needs, preferences and goals for community living.

B. This policy addresses the development of the Person-Centered Service Plan for individuals with (II. C) and without (II.B) a Targeted Case Manager (TCM).

C. Stakeholder roles and responsibilities will differ between the group that has a TCM and the group that does not.

II. Policy

A. Person-Centered Service Plan Components and Related Documents

a. ***Person-Centered Service Plan.*** The current "Integrated Service Plan" shall now be referred to as the "Person-Centered Service Plan."

i. The Person-Centered Service Plan and all associated processes conducted to establish a participant's finalized plan shall meet all requirements set forth in 42 CFR § 441.301, the requirements found within the 1915 (c) Home and Community Based (HCBS) waivers, and in K.A.R. 30-63-21 through 29, and K.A.R. 30-63.32.

ii. The Person-Centered Service Plan and associated process shall be the document of record demonstrating compliance with 42 CFR § 441.301, the requirements found within the 1915 (c) HCBS waivers, and when applicable, K.A.R. 30-63-1 through 32. No Person-Centered Service Plan shall be amended or otherwise changed without notifying the participant and in compliance with 42 CFR § 441.301, the 1915 (c) HCBS waivers, and K.A.R. 30-63-1 through 32.

iii. All enrollees of a 1915 (c) HCBS waiver shall have a Person-Centered Service Plan completed by their Managed Care Organization. MCOs may use contracted entities to assist in the development and monitoring of the plan, but will have primary responsibility for Person-Centered Service Plan development and accountability to deliver all Medicaid covered services, including HCBS, included in a member's Person-Centered Service Plan.

iv. The development of the Person-Centered Service Plan shall be conflict free, as defined by 42 CFR § 441.301 (c) (1) (vi).

v. All Person-Centered Service Plan templates and forms developed by MCOs must be submitted to KDADS for annual approval (every 365 calendar days), and prior to use. This requirement applies to any proposed changes to approved templates or forms. KDADS will have thirty (30) calendar days to approve or request changes to any templates or forms included in the Person-Centered Service Plan planning process.

b. **Person-Centered Service Plan Meeting.** The Person-Centered Service Plan meeting refers to, at a minimum, the annual (once every 365 calendar days or less), in-person meeting where a participant develops his or Person-Centered Service Plan with the support of any designated legal representatives, guardians, informal supports, or service providers requested by the participant. Unless otherwise specified by the participant, the meeting will always include the participant's assigned MCO Care Coordinator, as well as the participant's TCM. TCM applies when an individual receives services from the Intellectually/Developmentally Disabled (I/DD) waiver that includes state plan delivered TCM.

i. Additional Person-Centered Service Plan meetings may be necessary due to changes in condition or circumstance that require updates to the participant's plan, which would impact the scope, amount or duration of services included in the Person-Centered Service Plan. The following changes in condition or circumstance necessitate a Person-Centered Service Plan meeting to ensure the plan meets the participant's wishes and needs:

1. Change in functional ability to perform two or more Activities of Daily Living (ADLs) or three or more Instrumental Activities of Daily Living (IADLs) compared to the most recently assessed functional ability.

2. Change in behaviors that may lead to loss of foster placement or removal from the home.

3. Significant change in informal support availability, including death or long-term absence of a primary caregiver, and/or any participant identified changes in informal caregiver availability that results in persistent unmet needs that are not addressed in the most recently developed Person-Centered Service Plan.

4. Post-transition from any alternate setting of care (i.e.: state hospital, nursing home, etc.), when the participant was not residing in a community-based setting for thirty days or greater.

5. Upon the request of any waiver participant, guardian or legal representative.

6. Upon circumstances as defined in Article 63.

ii. A Person-Centered Service Plan meeting is to be held within 3 calendar days of MCO notification or awareness of necessitating circumstances. MCOs must conduct one face-to-face visit with the participant within 30 days of transitions from any alternate setting of care, after which the MCO must follow up with quarterly telephone calls and face-to-face visits every six months, with the exception of SED waiver participants, who must receive a face-to-face visit every three months.

c. ***Participant Interest Inventory (PII).*** The participant interest inventory is a Person-Centered Service Plan related document that allows the participant to self-assess personal preferences, strengths, weaknesses, and goals prior to completing the Person-Centered Service Plan meeting. The PII will replace the *Person-Centered Support Plan*, for I/DD waiver participants. A PII must be completed for all members receiving HCBS.

i. Impacted entities, including MCO Care Coordinators and TCMs will be required to use a standard PII format, approved by KDADS. The PII will include all elements of the previously termed person-centered support plan, as outlined in Article 63, 30-63-21, for all HCBS participants.

ii. Completion of the PII prior to the Person-Centered Service Plan meeting is not mandatory, but encouraged, to facilitate person centered planning activities performed by MCO Care Coordinators. A PII must be completed and documented before a Person-Centered Service Plan is finalized.

iii. Ensuring completion of the PII will be the responsibility of the MCO. The MCO may use a sub-contractor to facilitate PII completion. I/DD waiver participants will have their PII facilitated by their assigned TCM.

iv. Participants may use the assistance of non-paid supports, and should be encouraged to engage with non-paid supports when completing the PII.

v. PII components must be documented within the Person-Centered Service Plan document itself, it is the responsibility of the TCM or sub-contractor to ensure the PII is forwarded to the MCO for inclusion in the Person-Centered Service Plan record. Required components of the PII development process must include documenting an understanding of the participant's needs, wishes, strengths, and personal preferences.

d. ***Back-Up Plan.*** The back-up plan is a component of the Person-Centered Service Plan that documents how a participant's needs will be met when there are disruptions in the plan(s) established in the participant's Person-Centered Service Plan. The back-up plan will be the responsibility of MCOs to complete as part of the Person-Centered Service Plan process. MCOs must submit the back-up plan template to the State for approval prior to its use in the Person-Centered Service Plan process.

1. The back-up plan must clearly indicate if the participant has a "disaster red flag designation" as outlined in Section B.g.i. The disaster red flag designation provides an indication that the participant has an increased risk of harm during emergency or other disaster events. This is typically attributed to dependence on electricity for life sustaining equipment, dependence upon life

sustaining medication, etc.

2. Participants with a disaster red flag designation must have a documented individualized *disaster back up plan* that addresses how the participant's care, health and safety needs will be met in the event of natural or other disasters. An individualized disaster back up plan must also be developed and documented in the Person-Centered Service Plan for participants who live alone, have no documented informal supports, or reside in a HCBS residential setting.

e. ***Behavior Support Plan***. The behavior support plan is a component of the Person-Centered Service Plan that documents the plan for addressing and supporting behavior management of participants with behavior treatment needs or mental illness. This plan is to include methods that ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness.

i. The behavior support plan must meet all requirements as identified per KAR 30-63-23.

ii. In accordance with KAR 30-63-23, plans will be reviewed by a provider-established behavior management committee comprised of parties defined by regulation.

f. ***Participant Choice Form.*** The participant choice form is a standard form that educates participants on choice of services, providers, community-based vs. institutional alternatives, and self-direction vs. agency-direction models of service delivery. MCOs, or their designee, will be required to provide the form to participants or their legal representatives prior to the Person-Centered Service Plan meeting. The form also allows the participant to select the preferred format for the provision of all documents provided during the Person-Centered Service Plan. Section E.a includes more detail on the development and distribution of the Participant Choice form.

g. ***Rights and Responsibilities Form.*** The rights and responsibilities form will be

furnished by the MCO, or their designee, to all participants to provide current information on their rights as KanCare participants, and to outline the responsibilities of participants and those individuals who direct their person-centered care, per KAR 30-63-1 through 32 and the Shared Living Manual. Providers will still be required to uphold rights and responsibilities activities, specific to service delivery, as defined in state regulation.

III. Procedure

B. Step by Step Process for Autism, Frail Elderly, Physically Disabled, Technology Assisted and Traumatic Brain Injury Waiver Participants.

a. Person-Centered Service Plan *Meeting Selection and Coordination*

i. The participant or participant's legal representative, is responsible to identify who needs to attend the Person-Centered Service Plan meeting, in addition to the participant, participant designated legal representative, and MCO Care Coordinator, who are required to participate in person.

ii. The MCO Care Coordinator will then schedule an in- Person-Centered Service Plan meeting at a date and time when required participants can attend and actively participate, and invite known Person-Centered Service Plan providers, who may attend in-person, telephonically or through video conference modalities, at the discretion of the participant. MCOs shall make at least three attempts to schedule the in-person Person-Centered Service Plan meeting and shall document in writing if they receive no participant response after three attempts.

1. MCO Care Coordinators are required to participate in Person-Centered Service Plan meetings in-person, as stipulated in approved 1915 (c) HCBS waivers.

2. MCO Care Coordinators are responsible to ensure Person-Centered Service Plan meeting participants who attend via telephone or video

conference, are participating from a location that does not risk violation of privacy standards, such as the Health Insurance Privacy and Portability Act (HIPPA), including the improper sharing of protected health information about participants. MCO Care Coordinators must work with the participant and Person-Centered Service Plan participants to establish a meeting strategy that will allow remote participation without risk of improper disclosure of protected health information.

iii. The MCO shall honor and document in writing any specific participant requests to exclude a provider from participating in the Person-Centered Service Plan meeting.

iv. If any party requested by the participant declines to attend the Person-Centered Service Plan meeting, the MCO must obtain signed documentation from said parties, so as to demonstrate that parties were notified and refused to participate. In instances when a HCBS provider refuses to participate, the MCO Care Coordinator is responsible to notify KDADS of this refusal.

b. *Completion of the Participant Interest Inventory*

i. The MCO Care Coordinator is responsible to coordinate sending the PII to the participant, prior to the Person-Centered Service Plan meeting. The participant and/or participant representative will complete this document prior to the meeting, or during the Person-Centered Service Plan meeting, based on participant preference, with assistance from the MCO Care Coordinator as required.

ii. Participants are not required to complete the PII prior to the Person-Centered Service Plan meeting.

c. *Direction of the* Person-Centered Service Plan *Meeting*

i. The Person-Centered Service Plan meeting is to be directed by the participant, or legal representative as delegated by the participant. The MCO Care

Coordinator will support the participant or legal representative in leading the meeting and effectively coordinating the planning process.

d. *Review of the Participant Interest Inventory, Rights and Responsibilities Forms and Participant Preferences*

i. Review and/or facilitation of completing the PII and Rights and Responsibility form shall be included in the Person-Centered Service Plan meeting. These documents serve to ascertain the participant's input on their quality of life preferences, personal strengths, and additional community based needs and goals, to ensure person centered input is meaningfully incorporated into an established Person-Centered Service Plan.

ii. The MCO Care Coordinator is responsible to provide education and input about:

1. service options that will assist the participant in progress toward established goals,

2. identified care gaps, including assessing the participant's understanding of risks and consequences if gaps remain. The MCO Care Coordinator is additionally responsible in instances where a participant's preferences may put him or her at health or safety risk, to confirm that the participant demonstrates adequate understanding of risk, strategies to mitigate risks, consequences, and must make appropriate referrals to address risks.

3. restrictions to the participant's preferences, as stated in the PII or verbally,

4. additional community and social supports available to the participant, that may not be furnished directly by the MCO.

e. *Coordination with the Individual Educational Plan (IEP)*

i. If the participant has an Individual Educational Plan (IEP), the MCO Care Coordinator is required to coordinate both plans such that goals remain consistent between plans.

f. *Verification of Participant Selected HCBS Providers*

i. The MCO Care Coordinator is required to verify the qualifications of providers selected in the Person-Centered Service Plan, in accordance with respective requirements in appropriate waiver application appendices of the participant's assigned waiver.

g. *Development of the Back-Up Plan*

i. The MCO Care Coordinator shall document the participant's back-up plan during the annual Person-Centered Service Plan meeting. In addition, the MCO shall monitor the implementation of the established back-up plan, including performing any necessary updates to the back-up plan for inclusion in the participant's records.

1. The MCO Care Coordinator must clearly indicate if the participant has a "disaster red flag designation" within the back-up plan.

2. Participants with a disaster red flag designation must have a documented *disaster back up plan* that addresses how the participant's care and health and safety needs will be met in the event of natural or other disasters.

h. *Documenting Participant Understanding of the* Person-Centered Service Plan

i. The MCO Care Coordinator is required to obtain a signature of understanding from the participant or participant's legal representative prior to implementation of the Person-Centered Service Plan. The plan's contents must be clearly documented, including the type, amount and duration of services established based on participant assessment and Person-Centered Service Plan development, when a signature is obtained.

ii. A participant or participant's legal representative must sign to acknowledge understanding and agreement or disagreement of the Person-Centered Service Plan whenever content adjustments are made that change the scope, amount or duration of services within the plan, including interim changes. Participant signature does not waive a participant's right to file a grievance or appeal.

iii. If the participant or participant's legal representative declines signing the Person-Centered Service Plan, the MCO Care Coordinator is required to document in writing this refusal, notify KDADS, and demonstrate at least three (3) documented attempts to obtain signature, which include:

1. live telephonic contact with the participant or participant's legal representative
    a. voicemails left with no response are not considered as "live contact"

2. in-person contact, conducted at either the participant's home, a provider location, or at a site selected by the participant.

iv. Documented correspondence must be sent, via the form of delivery indicated on the Participant Choice Form, by the MCO to the participant advising that the Person-Centered Service Plan will not be implemented due to failure to obtain participant signature.

v. It is the responsibility of the MCO Care Coordinator to clearly educate the participant, or participant's legal representative that signing Person-Centered Service Plan may not imply full agreement with the content of the plan. MCOs retain the flexibility to design a participant-friendly signature page, but the template will be subject to the review and approval of the State.

vi. MCO Care Coordinators shall document that they provided education ~~of~~ for the participant explaining that their signature does not preclude the participant's ability to file a grievance or appeal the contents of the Person-Centered Service Plan.

vii. The MCO Care Coordinator must provide documentation of the Person-Centered Service Plan and any Person-Centered Service Plan related documents using the preferred format indicated in the Participant's Choice form. If the he or she chooses, a participant or participant's legal representative may request a paper copy of their Person-Centered Service Plan for signature, in lieu of signing an electronic format.

i. *Documenting Provider Understanding of the* Person-Centered Service Plan

i. The MCO Care Coordinator is responsible to coordinate a signed statement of understanding and consent to deliver with the participant's established Person-Centered Service Plan from all service providers identified in the plan of care who will participate in the delivery of services included in the Person-Centered Service Plan. The participant may also request that their primary or specialty care providers sign their plan, if this request is made, the MCO Care Coordinator is responsible to obtain signature from these providers.

ii. Provider signature does not constitute approval or denial of the Person-Centered Service Plan. Provider signatures indicate an understanding of the Person-Centered Service Plan contents, and denotes a willingness and ability to deliver services within the scope, amount and duration established in the Person-Centered Service Plan.

1. In the event the provider originally selected refuses to sign a statement of agreement, the MCO Care Coordinator is responsible to provide education to the participant on other service providers.

iii. When interim changes are made to a participant's Person-Centered Service Plan that change the scope, amount or duration of services within the plan, the MCO Care Coordinator must also obtain a signature from the impacted service providers.

iv. Providers who fail to sign a statement of agreement will not be paid for services provided prior to MCO receipt of a signed statement from the provider.

j. *Obtaining Physician/RN Statements for Health Maintenance Activities Supervised and Directed using a Consumer Directed Attendant/Personal Care Worker*

i. The MCO Care Coordinator shall obtain a physician's statement certifying the supervision plan for performance of health maintenance activities.
   1. The statement shall include documentation of the health maintenance activities and the identified supervising party.

ii. The MCO Care Coordinator shall include the completed documentation in the Person-Centered Service Plan.

k. *Confirming Appointed Designated Representatives and Paid Guardians*

i. The Person-Centered Service Plan must clearly indicate if the participant has a designated legal representative and/or guardian, and whether the guardian is paid.

ii. The MCO Care Coordinator is responsible to ensure the participant record includes designated representative and guardian details, including name, contact information and paid / unpaid status.

l. *Providing a Finalized* Person-Centered Service Plan

i. The MCO Care Coordinator is responsible to supply the participant or participant's legal representative with a final Person-Centered Service Plan, once all parties have signed the agreement. The MCO Care Coordinator shall sign the Person-Centered Service Plan as documentation of their participation in developing the Person-Centered Service Plan. The final v is to be provided to the participant according to the method selected in the participant's completed choice form, within 30 calendar days of the Person-Centered Service Plan meeting.

ii. The MCO Care Coordinator shall document participant confirmation of receipt, either with date, time and method of confirmation, or by certified

receipt via the United States Postal Service.

iii. The MCO Care Coordinator is responsible to supply each of the participant's applicable providers with the appropriate health and safety risk factors from the Person-Centered Service Plan and provide only the necessary information from within the Person-Centered Service Plan pertinent to delivering assigned services to the participant.

m. *Monitoring Implementation of the* Person-Centered Service Plan

i. Once MCO Care Coordinators complete the Person-Centered Service Plan process they are required to monitor delivery of the plan, including conducting a six-month face-to-face visit with the participant or participant's legal representative.

ii. The MCO Care Coordinator must document all contact with the participant or participant's legal representative, and update the Person-Centered Service Plan accordingly.

C. Step by Step Process for IDD and SED Waiver Participants

a. In the event an IDD or SED participant does not have a TCM, the MCO Care Coordinator will complete the TCM responsibilities.

b. Person-Centered Service Plan *Meeting Selection and Coordination*

i. The participant or participant's legal representative is responsible to identify who needs to attend the Person-Centered Service Plan meeting, in addition to the participant, participant designated representative, and MCO Care Coordinator, who are required to participate.

ii. The MCO Care Coordinator is required to ask the participant if he/she wishes for his/her chosen TCM to participate. If the participant authorizes the TCM's attendance, the MCO Care Coordinator is to consider the TCM as a required participant.

1. MCO Care Coordinators are required to participate in Person-Centered Service Plan meetings in-person, as stipulated in approved 1915 (c) HCBS waivers.

2. MCO Care Coordinators are responsible to ensure that Person-Centered Service Plan meeting participants who attend via telephone or video conference, are participating from a location that does not risk violation of privacy standards, such as the Health Insurance Privacy and Portability Act (HIPPA), including the improper sharing of protected health information about participants. MCO Care Coordinators must work with the participant and Person-Centered Service Plan participants to establish a meeting strategy that will allow remote participation without risk of improper disclosure of protected health information.

3. Ensuring completion of the PII will be the responsibility of the MCO. The MCO may use a sub-contractor to facilitate PII completion. I/DD waiver participants will have their PII facilitated by their assigned TCM.

iii. The MCO Care Coordinator shall schedule an in-person Person-Centered Service Plan meeting at a date and time when required participants can attend and actively participate. The Care Coordinator shall invite known Person-Centered Service Plan providers to attend unless otherwise directed by the participant.

iv. The MCO shall honor and document any specific participant requests to exclude a TCM from participating in the Person-Centered Service Plan meeting.

v. The MCO shall honor and document any specific participant requests to exclude a provider from participating in the Person-Centered Service Plan meeting.

vi. If any party requested by the participant declines to attend the Person-Centered Service Plan meeting, the MCO must obtain signed documentation from said parties, to demonstrate that parties were notified and refused to participate. In instances when a HCBS provider or TCM refuses to participate, the MCO Care Coordinator is responsible to notify KDADS of this refusal.

c. *Completion of the Participant Interest Inventory Prior to the* Person-Centered Service Plan *Meeting*

i. The MCO Care Coordinator is responsible to coordinate sending the PII, prior to the Person-Centered Service Plan meeting.

1. For initial Person-Centered Service Plan meetings, the MCO shall notify the TCM of the need for the PII no later than three (3) days in advance of the meeting date to allow the TCM sufficient time to assist participant with completing the PII.
2. For annual redetermination meetings, MCOs shall notify the TCM of the need for a completed PII no later than 30 days prior to the anticipated meeting date.
3. For meetings due to change in condition – MCOs shall notify the TCM of a need for an updated PII no later than 24 hours before the anticipated meeting.

ii. The TCM is required to assist the participant with completing the PII prior to holding the Person-Centered Service Plan, and is responsible to ensure that the MCO Care Coordinator receives the document to include in Person-Centered Service Plan documentation.

1. In instances where there is a Person-Centered Service Plan meeting due to an unanticipated change in circumstance or condition, the TCM is expected to do due diligence in facilitating a PII, but is not required to update the PII prior to the Person-Centered Service Plan meeting.

iii. The TCM is required to document participant refusal to complete the PII prior

to the Person-Centered Service Plan meeting, and notify the MCO Care Coordinator, if applicable.

iv. The TCM is responsible for reviewing and obtaining participant signature for the *Participant Choice Form* and *Rights and Responsibilities Forms*, and must submit completed documents to the MCO Care Coordinator within five (5) business days of completing the form(s).

d. Direction of the Person-Centered Service Plan *Meeting*

i. The Person-Centered Service Plan meeting is to be directed by the participant, or legal representative as delegated by the participant. The MCO Care Coordinator and TCM will support the participant or legal representative in leading the meeting and effectively coordinating the planning process.

e. Review of the Participant Interest Inventory and Participant Preferences

i. The Person-Centered Service Plan meeting shall include review of the PII, to ascertain the participant's input on their quality of life preferences, personal strengths, and additional community based needs and goals, to ensure person-centered input is meaningfully incorporated into the Person-Centered Service Plan.

While the MCO Care Coordinator has primary responsibility for development and delivery of the Person-Centered Service Plan, the TCM is responsible to support development of the PII and the referral process, The TCM is responsible to provide education and input about:

1. service options that will assist the participant in progress toward established goals,

2. identified care gaps, including assessing the participant's understanding of risks and consequences if gaps remain. The TCM is responsible in instances where a participant's preferences may put him

or her at health or safety risk, to confirm that the participant demonstrates adequate understanding of risk, strategies to mitigate risks, consequences, and make appropriate referrals to address risks.

3. restrictions to the participant's preferences as stated in the PII or verbally,

   a. As part of the behavior support plan for IDD and SED populations, the TCM shall assist with identification of any restrictions to the participant's preferred lifestyle and will gather and provide information to the MCO and team regarding the following:

      i. Informed consent

      ii. A specific and individualized need;

      iii. Documentation of the positive interventions and supports used prior to restrictions,

      iv. Less restrictive alternatives tried,

      v. The reason for the restriction (other than disability),

      vi. Frequency of use,

      vii. How often the behavior plan is reviewed and by whom,

      viii. Who collects the data,

      ix. Assurances that the interventions used will cause no harm to the individual,

4. additional community and social supports available to the participant,

that may not be furnished directly by the MCO.

5. aligning the contents of the PII with the contents of the behavioral support plan to ensure coordination and avoid duplication. Section l.i includes additional details regarding the completion of the behavioral support plan.

f. Coordination with the Individual Educational Plan (IEP)

i. If the participant has an Individual Educational Plan (IEP), the MCO Care Coordinator is required to coordinate with the TCM, where applicable, to ensure that both plans have consistent goals and objectives

g. Verification of Participant Selected HCBS Providers

i. The MCO Care Coordinator is required to verify the qualifications of providers selected in the Person-Centered Service Plan, in accordance with respective requirements in appropriate waiver application appendices of the participant's assigned waiver.

h. Development of the Back-Up Plan

i. The participant's MCO Care Coordinator is responsible to coordinate with the TCM to ensure the participant's back-up plan is updated during the annual Person-Centered Service Plan meeting. In addition, the MCO shall monitor the implementation of the established back-up plan, including performing any necessary updates to the back-up plan and ensure updated documentation is forwarded to the TCM for inclusion in the participant's records.

1. It shall be clearly indicated if the participant has a "disaster red flag designation" within the back-up plan.

2. Participants with a disaster red flag designation must have a documented *disaster back up plan* that addresses how participant's care, health and safety needs will be met in the event of natural or

other disasters.

i. *Documenting Participant Understanding of the* Person-Centered Service Plan

i. The MCO Care Coordinator is required to obtain a signature of understanding from the participant or participant's legal representative prior to implementation of the Person-Centered Service Plan. The plan's contents must be clearly documented, including the type, amount and duration of services established based on participant assessment Person-Centered Service Plan development, when a signature is obtained.

ii. If the participant or participant representative declines signing the Person-Centered Service Plan, the MCO Care Coordinator is required to document this refusal, notify KDADS of the refusal, and demonstrate at least three (3) documented attempts, which include:

1. live telephonic contact with the participant or participant's legal representative.
    a. voicemails left with no response are not considered as "live contact"

2. in-person contact, conducted at either the participant's home, a provider location, or at a site selected by the participant.

iii. Documented correspondence must be sent, via the form of delivery indicated on the Participant Choice Form, by the MCO to the participant advising that the Person-Centered Service Plan will not be implemented due to failure to obtain participant signature.

iv. It is the responsibility of the MCO Care Coordinator to clearly educate the participant, or participant's legal representative that signing the Person-Centered Service Plan may not imply full agreement with the content of the plan. MCOs retain the flexibility to design a participant-friendly signature page, but the template will be subject to the review and approval of the State.

v. MCO Care Coordinators shall document that they provided education ~~of~~ for the participant explaining that signature does not preclude the participant's ability to grieve or appeal the contents of the Person-Centered Service Plan.

j. *Documenting Provider Understanding of the* Person-Centered Service Plan

i. The MCO Care Coordinator is responsible to coordinate a signed statement of understanding and consent to deliver with the participant's established Person-Centered Service Plan, from all service providers identified in the plan of care who will participate in the delivery of services included in the Person-Centered Service Plan. The participant may also request that their primary or specialty care providers sign their plan, if this request is made, the MCO Care Coordinator is responsible to obtain signature from these providers.

ii. Provider signature does not constitute approval or denial of Person-Centered Service Plan. Provider signatures indicate an understanding of Person-Centered Service Plan contents, and denotes a willingness and ability to deliver services within the scope, amount and duration established.

1. In the event the provider originally selected refuses to sign a statement of agreement, the MCO Care Coordinator is responsible to provide education to the participant on other service providers.

iii. When interim changes are made to a participant's Person-Centered Service Plan that change the scope, amount or duration of services within the plan, the MCO Care Coordinator must also obtain a signature from the impacted service providers.

iv. Providers who fail to sign a statement of agreement will not be paid for services provided prior to receipt of a signed statement from the provider.

k. *Obtaining I/DD Waiver-Specific Physician's Statements*

i. The MCO Care Coordinator is required to obtain the physician's statement for

Health Maintenance Activities (HMA) or in-home I/DD Day Services, if those services are included in the participant's Person-Centered Service Plan.

ii. The TCM is responsible to coordinate with the MCO Care Coordinator to ensure completed documentation is forwarded to the MCO for inclusion in Person-Centered Service Plan documentation.

l. *Confirming Appointed Designated Representatives and Paid Guardians*

i. The Person-Centered Service Plan must clearly indicate if the participant has a designated legal representative and/or guardian, and whether the guardian is paid.

ii. The TCM is responsible to coordinate with the MCO Care Coordinator to ensure the participant record includes designated representative and guardian details, including name, contact information and paid / unpaid status.

m. *Completion of the Behavioral Support Plan*

i. The participant's chosen TCM or applicable provider, is required to complete the Behavior Support Plan, when applicable, in conjunction with impacted providers or external entities included by the provider. The completed plan must meet all requirements of K.A.R. 30-63-23.

ii. The completed behavior support plan is to be shared with the MCO Care Coordinator within 5 business days of finalization, at which time the MCO Care Coordinator must update Person-Centered Service Plan accordingly. This standard is applicable to all instances when the behavior support plan is changed or updated.

n. *Providing a Finalized* Person-Centered Service Plan

i. The MCO Care Coordinator is responsible to supply the participant or participant's legal representation with a final Person-Centered Service Plan, once all parties have signed the agreement. The MCO Care Coordinator shall

also sign the Person-Centered Service Plan as documentation of their participation in the process. The final Person-Centered Service Plan is to be provided to the participant according to the method selected in the participant's completed choice form, within 30 calendar days of the Person-Centered Service Plan meeting.

ii. The MCO Care Coordinator must document participant confirmation of receipt, either with date, time and method of confirmation, or by certified receipt via the United States Postal Service.

iii. The MCO Care Coordinator is responsible to supply each of the participant's applicable providers with the appropriate health and safety risk factors from the Person-Centered Service Plan and provide only the necessary information from within the Person-Centered Service Plan pertinent to delivering assigned services to the participant, within 30 calendar days of the Person-Centered Service Plan meeting.

iv. The MCO Care Coordinator is responsible to supply the participant's TCM with a copy of the finalized Person-Centered Service Plan within 30 calendar days of the Person-Centered Service Plan meeting.

o. *Monitoring Implementation of the* Person-Centered Service Plan

i. The participant's chosen TCM is responsible to provide ongoing monitoring of progress toward Person-Centered Service Plan goals. In addition, the TCM shall make referrals for additional resources as needed, for participants on the I/DD waiver, SED waiver, and individuals on the I/DD waiting list. The TCM must coordinate with the MCO Care Coordinator in the event there is a change in Person-Centered Service Plan goals.

ii. The MCO Care Coordinator is required to monitor delivery of the Person-Centered Service Plan, including completion of a six-month face-to-face visit.

D. Required Timelines, Person-Centered Service Plan Distribution, and Participant

Contact Requirements

a. Required Timelines

i. Each KanCare MCO shall meet all required timeframes regarding the Person-Centered Service Plan found in the respective 1915 (c) HCBS Waiver, and the KanCare MCO Contracts.

ii. For new 1915 (c) HCBS Waiver participants:

1. The participant signed Person-Centered Service Plan shall be complete within 14 business days from notification that a participant has been coded by the KDHE Clearinghouse for waiver services.

   The final, provider signed Person-Centered Service Plan shall be implemented and services are to begin within 14 business days from notification of participant waiver approval.

iii. For existing 1915 (c) HCBS Waiver participants:

1. The annual Person-Centered Service Plan must be completed within 365 days of the previous plan.

2. The MCO Care Coordinator shall hold a face-to-face meeting with the participant at least every 6 months, except for participants of the SED waiver, who must be met with face-to-face every 3 months.

3. The MCO Care Coordinator shall update the Person-Centered Service Plan within 10 business days upon receipt of notification of any of the events defined in Section A.b.i. of this policy that warrant reconsideration of the active Person-Centered Service Plan.

4. The waiver participant, legal representative, guardian, and applicable service providers shall sign the plan within 14 days from finalization of an updated Person-Centered Service Plan, if the updated plan includes a change in service, service amount, or designated service

provider. In the case of an updated Person-Centered Service Plan, only the service providers associated with Person-Centered Service Plan changes will be required to sign the updated plan.

E. Rights and Protections for Participants

a. Distribution of the Participant Choice Form

i. For all HCBS waivers, except the I/DD waiver, the MCO shall provide the waiver participant with a participant choice form. The form shall include a choice of providers, services, community vs. institutional alternative, and self-direction vs. agency direction, signed by the participant or participant's legal representative.

ii. For the I/DD waiver, the CDDO shall provide the waiver participant with a participant choice form and send the completed form to the participant's MCO. The form shall include a choice of providers, services, community vs. institutional alternative, and self-direction vs. agency direction, signed by the participant or participant's legal representative.

iii. If a participant chooses services outside of their current CDDO area, the participant's current CDDO and MCO shall coordinate with the desired CDDO area to communicate the participant's choice. The CDDO serving the selected service area shall than offer the participant choice form.

iv. The MCO Care Coordinator must document verification that information was received and understood regarding reporting of abuse, neglect, and exploitation; rights & responsibilities, and process for appeals and grievances, signed by the participant or participant's legal representative.

b. Assignment and Changing MCO Care Coordinators

i. A participant has the right to request a new MCO Care Coordinator. MCOs must document requests for re-assignment to a new Care Coordinator, and re-assign MCO Care Coordinators within 14 business days.

ii. For new MCO Care Coordinator assignments and any MCO Care Coordinator re-assignments due to any circumstance, the participant or participant's legal representative must be notified in writing, within 30 calendar days of the change.

1. Notification shall include:

a. instructions for contacting the newly assigned Care Coordinator directly and toll-free

b. instructions for a toll-free line that provides direct contact with a live person in the event the Care Coordinator is unavailable to answer participant questions

c. Conflict Resolution

i. Participants and participant legal representatives retain the right, always, to disagree with the process and/or outcome of person-centered planning and Person-Centered Service Plan contents.

1. If the MCO is unable to resolve a Person-Centered Service Plan related conflict with the participant, the MCO must facilitate a "warm transfer" to the KanCare Ombudsman, who will then assist with the following actions:

a. Engaging the MCO in informal conflict resolution activities, the outcome of which is to be documented by both the MCO Care Coordinator, as well as the KanCare Ombudsman.

b. Referring unresolvable conflict to state officials within Kansas Department of Aging and Disabilities or Kansas Department of Health and Environment, as necessary to ensure the safety and wellbeing of participants.

c. Assist participants to understand the State's Medicaid fair

hearing process, grievance and appeal rights, and assist participants in navigating those processes and/or accessing community legal resources, if needed/requested.

F. Quality and Documentation

a. The Person-Centered Service Plan shall be the document utilized to demonstrate compliance with 42 CFR § 441.301, K.A.R. 30-63-1 through 32, and the 1915 (c) HCBS waivers.

b. The waiver participant or legal representative's signature, shall be required to meet all waiver *Plan of Care* performance measures provided in the HCBS 1915 (c) waivers.

c. The choice of providers offered to individuals shall be consistent with the time and distance or other standards adopted by KDADS. A choice of state-wide providers shall not be required unless specifically requested by the waiver participant.

Definitions

Activities of Daily Living (ADL)- routine activities that people tend to do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence.

Agency-directed- the traditional service delivery model. A qualified agency hires, fires, pays and trains direct service workers to provide services to individuals.

Alternate Setting of Care- includes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), Psychiatric Residential Treatment Facilities (PRTF), Nursing Facilities, State Hospitals and settings of incarceration.

Disaster Red Flag Designation- An indication an individual has increased risk of harm during emergency or other disaster events. This is typically attributed to dependence on electricity for life sustaining equipment, dependence upon life sustaining medication, etc.

Health Maintenance Activities: include monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, wound care, range of motion, reporting changes in functions or condition, and medication administration and assistance.

Instrumental activities of daily living (IADL)- activities often performed by a person who is living

independently in a community setting during the course of a normal day. IADLs include managing money, shopping, telephone use, travel in the community, housekeeping, preparing meals and taking medications correctly.

Individual Educational Plan (IEP)- defined by the Kansas Special Education Services Process Handbook as "as a written statement for each student with an exceptionality which describes that child's educational program and is developed, reviewed, and revised in accordance with special education laws and regulations."

Legal Representative – refers to any durable power of attorney or legal representative assigned by court or selected by the participant, and/or legal guardian.

Person-Centered Service Plan - a written service plan developed jointly with an individual (and/or the individual's authorized representative) that reflects the services and supports that are important for the individual to meet the needs identified through a needs assessment, what is important to the individual with regard to preferences for the delivery of such services and supports and the providers of the services and supports. (42 CFR § 441.725(a) and (b)).

Person Centered Support Plan- a written plan that contains a description of the person's preferred lifestyle, the activities, training materials, equipment, assistive technology and services that are necessary to assist the person in achieving their preferred lifestyle. (K.A.R. 30-63-21)

Self-Direction- participants or their representatives have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports.

Warm Transfer- the individual is connected to a new staff member such that the individual does not need to repeat their story to different workers.

Authority

1915(c) HCBS Waivers

Federal Authority 42 CFR 441.301 Contents of request for a waiver

State Authority
K.A.R. 30-63-1 through 32. Person-centered support planning; implementation

Policy Name:	HCBS Person-Centered Service Plan Policy	**Policy Number:**	TBD
Commission:	Community Services and Programs Commission	**Date Established:**	TBD
Applicability:	All HCBS 1915 (c) Waivers	**Date Last Revised:**	N/A
Contact:	HCBS-HCBS Director	**Date Effective:**	TBD
Policy Location:	https://www.kdads.ks.gov/commissions/home-community-based-services-(hcbs)/hcbs-policies	**Date Posted:**	TBD
Status/Date:	DRAFT 12/15/17	**Number of Pages:**	29 of 29
Revision History			

Related Information

PUBLIC COMMENT PERIOD:

Posted Online: Comment Period Ends: 1/28/2018
Questions & Comments submitted to HCBS-ks@kdads.ks.gov